

# My Diabetes Action Plan

My name: \_\_\_\_\_

Date: \_\_\_\_\_

My address: \_\_\_\_\_

Name of my doctor or clinic: \_\_\_\_\_

Phone number of my doctor or clinic: \_\_\_\_\_

Who to contact for me in case of an emergency:

(Name) \_\_\_\_\_

(Phone number) \_\_\_\_\_

**Your Healthcare Plus** phone number : 1-800-973-6792

Illinois Nurse Consultation Line phone number (to call when my doctor's office is closed): to come

**The ABC's of diabetes control. I should ask my doctor or clinic about:**

- ☐ Aspirin once a day to protect my heart and an A1C test every 6 months
- ☐ Blood pressure control
- ☐ Cholesterol control

## Know my targets

### Blood Pressure: 130/80 or less

What is mine? \_\_\_\_\_

When was it last checked? \_\_\_\_\_

### Blood Sugar: A1C of less than 7%

What is mine? \_\_\_\_\_

When was it last checked? \_\_\_\_\_

### Bad Cholesterol: LDL less than 100

What is mine? \_\_\_\_\_

When was it last checked? \_\_\_\_\_

### Flu Shot: every fall

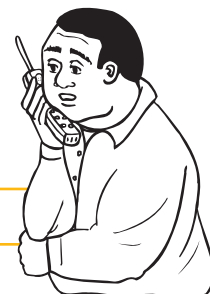
When did I last get a flu shot? \_\_\_\_\_

**I will talk to my doctor or clinic TODAY if:**

1. I have chest pain or tightness.
2. I feel weak or have tingling on one side of my body.
3. I have new vision or speech problems.
4. I feel burning when I go to the bathroom.

5. I have new sores or redness on my feet.
6. I feel dizzy or confused.
7. I feel thirstier than usual. I need to go to the bathroom more than usual.

**I should go to the ER or call 911 if:**



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My medicines	How much medicine to take	Reason I am taking this medicine
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		



### Things I should do:

1. Check my feet every day for sores.
2. Wear proper shoes.
3. Take all my medicines as the doctor or clinic prescribed.
4. Tell my doctor or clinic about any problems with my medicines.
5. Wear or carry something that says I have diabetes.

### My diet and exercise plan.

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